MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13612

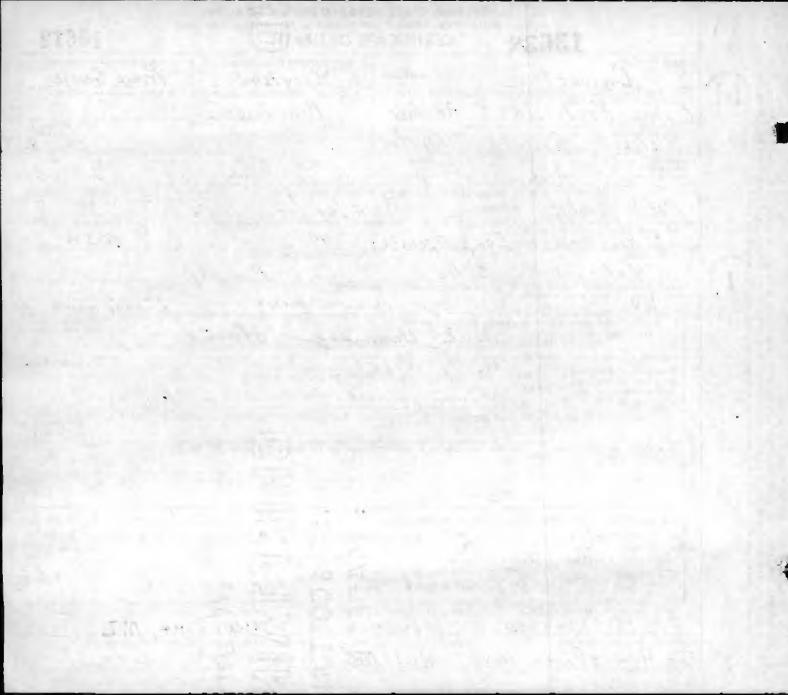
		1000					10010
1.	PLACE OF DEATH	lvert	MARYLAND	2. USUAL RESIDENCE (WHO O. STATE Mary /		institution Residence	George
1	PRURAL and give ne	1 11	20 1	c. CITY OR TOWN (IF o	outside corporote limits,	write RURAL and give	e nearest town)
	d. NAME OF HOSPITA OR INSTITUTION	AL (If not in hospital, give str COUNT	1 1000	d. STREET ADDRESS	y wine	/	e. IS RESIDENCE ON A FARM? YES NO
	NAME OF DECEASED (Type or print)	Andrew	Middle D	Baden	4. DATE OF DEATH	Month 12	2 1961
5. 5	Male		ARRIED NEVER MARRIED DWED DIVORCED	8. DATE OF BIRTH 11 24 64	9. AGE (In lost birt	1 1	YEAR IF UNDER 24 HE oys Hours Min.
2	tate Node	ing life, even if retired)	ob. KIND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (Stole	or foreign country)		1.5 A
13.	FATHER'S NAME	bert	Baden	14. MOTHER'S MAIDEN N	Murphy		
15. (Ye	WAS DECEASED EVER	IN U. S. ARMED FORCES? If yes, give war or dates of service)	4	abel Bade	h	Brand,	wine,
		TH [Enter only one couse per TH WAS CAUSED BY: IMMEDIATE CAUSE (0)	acity Hen	unhog (Short/	/	INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if or	(0)	ia of Reco	tum -			2 week
	couse (o), stoting I lying couse lost.	he under- DUE TO	aboliumo peris	ue Resse	7-0	1/12/60	
CATION			ns <u>contributing to death</u> bu	T NOT RELATED TO THE TERMI	INAL DISEASE CONDITI	ON GIVEN IN PART I	PERFORMED?
L CERTIF	200. ACCIDENT WA OR CONTRIBUTING (IF EITHER, NOTIFY	S UNDERLYING [] 20b, CAUSE OF DEATH MEDICAL EXAMINER)	DESCRIBE HOW INJURY OCCURRE	ED. (Enter noture of injury in	Port I or Port II of item	18.)	
MEDICA	20c. TIME OF INJURY Hour o.m. p. m.	W		ACE OF INJURY (Home, farm octory, street, office bldg., etc		(Cou	unty) (Stot
	21. I certify that	14	ended the deceased fram.	113	M, fram the caus		., that (I) (we) la
	220. SIGNATURE	Edwillon	1 A	/	ED STAFF PHYS.		22b, DATE SIGNE
	22c. PHYSICIAN'S NAME (Type)	RdEVI	LLARREALM	22d. ADDRESS 5	t hen	rord	15/1/
230	BURIAL, CREMATION PEMOVAL (Specify)	N. 236. DATE THEREOF	230, NAME OF CEMETERY OF	OR CREMATORY	23d. LOCATION (City,	town, or county)	(Stote)
24.	FUNERAL DIRECTOR'S		ADDRESS	250. REC'	1	b. REGISTRAR'S SIGN	
1 6	5 m - 1/1/2	F 122 10 13 1 1	35 MRCW [115] [1 x 1]	PARTE DATE D	LIPE CONTROL	777 -	ALC: A

moy be retaint. By the hospital or ottending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the buriol-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to buriol, cremation, or removal, and in any event with a 22 hours after death. death. Page ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 haurs,

TO HOSPITAL

VR A15 (4) 15M B/59



VS A1S (4) 15M 10/57

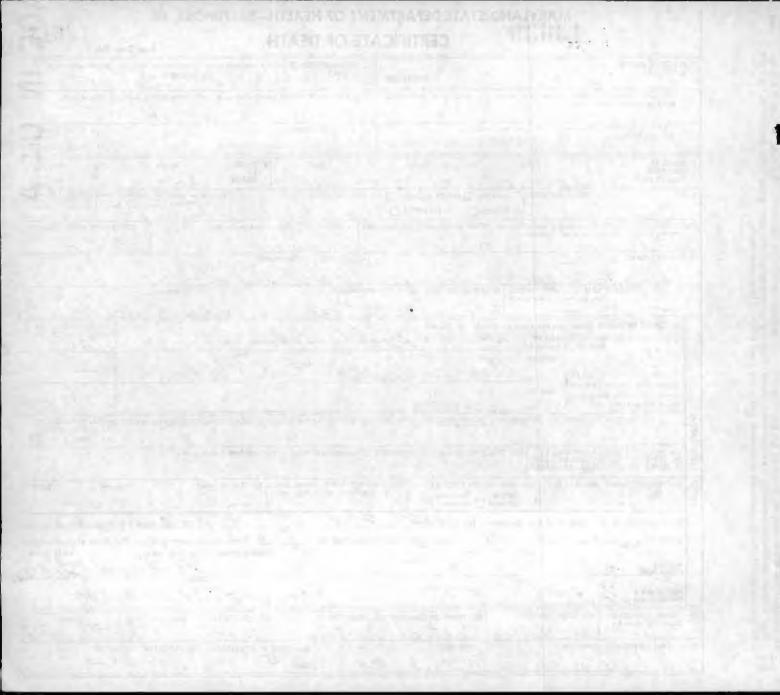
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 13639 CERTIFICATE OF DEATH

CERTIFICATE OF DEATH

13613 Reg. Dist. No.

1. PLACE OF DEATH	vert	MARYLAN	II o STATE /	NCE (Where deceased I	b. COUNTY	sidence before ad	mission)
b. CITY OR TOWN RURATION give r	(If autside carporate limits, write nearest town)	c. LENGTH OF STAY IN 1	c CITY OR TO	OWN (If outside corpora	to limits, write RURAL	and give nearest	lawn)
d. NAME OF HOSPI OR INSTITUTION	ITAL (If not in haspital, give street	oddress)	d. STREET AD	DRESS		0	RESIDENCE N A FARM?
3. NAME OF DECEASED (Type or print)	Lawrence	Randle	Gray	4. DATE OF DEATH	Dec.	Day 15	Yeor 1960
5. SEX Male	6. COLOR OR RACE 7. MAR WIDOW	RIED NEVER MARRIED DIVORCED	8. DATE OF BIRTH	15 1869	AGE (In years IF UN lost birthdoy) Moni	IDER I YEAR IF U	NDER 24 HRS.
during most of wo	ON (Give kind of work done 10b. tking life, even if refired)	Farm	DUSTRY 11. BIRTHPLAC	CE (State or foreign cou	ntry) 12	CITIZEN OF WI	A .
13. FATHER'S NAME La faye)	te Broom e	Grau	Chris	Stiana	Bowen		
15. WAS DECEASED EV	ER IN U. S. ARMED FORCES? 16.	50 CIAL SECURITY NO. 17	Luttle7	on L.G	ray liv	ace Frede	ench M
Conditions, if a gove rise lo couse (o), sloting lying couse last.	immediate DUE TO	leart De Elenavele Trema	ithe	(dan S	topes	ONSET A	S-//co
CATI	HER SIGNIFICANT CONDITIONS					PE	RFORMED?
THE EITHER, NOTIFY	AS UNDERLYING 206, DES G CAUSE OF DEATH MEDICAL EXAMINER	CRIBE HOW INJURY OCCUI	RED. (Enter noture of i	injury in Part I or Part I	l of item 18.)		
20c. TIME OF INJUI Hour a.m. p. m.	While		PLACE OF INJURY (Ho factory, street, office b	ame, form, 20f. (City a	r town)	(County)	(State)
21. I certify all alive on ACTUAL SIGNAMUSE PHYSICIAN'S NAME (Type)	bat I attended the decease LACE AGE COLUMN	57/	ath accurred at.		19 M, tha the causes and o et, city of Gwn, stolel TREDS		
22a. BURIAL, CREMATIC REMOVAL (Specify		Central	OR CREMATORY Cemeters	22d. 10CATIC	N (City, lown, or cour	livert 6	Stote)
23. FUNERAL DIRECTOR	SSIGNATURE CAMPILL	Mutual	no 1	AND DEC 2 1 260		S SIGNATURE	,



MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13640 Reg. Dist. No. crematia PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) D. STATE b. COUNTY MARYLAND burial, b. CITY OR TOWN (if outside corporale limits, write RUBAL c. LENGTH OF STAY IN 16 c. CITY OR TOWN (If butide corporate limits, write RURAL and give nearest town) and give nearest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS prior ON A FARM? YES NO PO 3. NAME OF First: Middle DATE Losf Month Dow Year DECEASED OF DEATH (Type or print) 19 5. SEX 6. COLOR OR RACE 7. MARRIED T NEVER MARRIED T 9. AGE (In years IF UNDER TYEAR IF UNDER 24 HRS. 8/BATE OF BIRTH Months Days Hours Min. WIDOWED I DIVORCED | YES. 10a. USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (Slote or fereign country) during most of working fits, even if retired) 12. CITIZEN OF WHAT COUNTRY? 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME WAS DECEASED EVER IN U. S. ARMED-FORCES? 16. SOCIAL SEGURITY NO. 17, INFORMANT 18. CAUSE OF DEATH | Enter only one couse per line for (o), (b), and (c). MERVAL BETWEEN PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (q). **DUE TO** Conditions, if any, which alang burial gove rise to immediate cause **DUE TO** (o), stoting the underlying cause lost. 0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN TN PART 1(0) 19, WAS AUTOPS SO PERFORMED? NOF win 20g. EXTERNAL CAUSE WAS 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port, I or Port II of item 18.) PRIMARY OF CONTRIBUTING CAUSE OF DEATH. Month, Day, Year 20d ANJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20c. TIME OF INJURY 20f. (Cily or lown) (Stote) factory, street, office bldg., etc.) While Not while of work a sal work 21. I certify that I took charge of the remains described above, held an Autapsy , Inspection Inquiry and find that to the Chief DIRECTOR: F death resulted from: Natural causes Accident . Suicide . Hamicide Undetermined cause 5 DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE forwarded to ASSISTANT MEDICAL EXAMINER EXAMINER'S DEPUTY MEDICAL EXAMINER NAME (Type) 220. BUBYAL, CREMATION, 226. DATE THEREOF 22c. NAME OF CEMEJERY OR CREMENRY 22d. LOCATION (City, Jown, or county) (Stote) REMOVAL (Specify) 23. FUMERAL DIRECTOR'S SIGNATURE ADDRESS A40. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE VS. A15ME(5) DATEDEC 1 5 '60 Curther & Thomas 5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Pages ate,

13641 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Rea, Dist. Na PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution / Résidence before admission) o. COUNTY O. STATE b. COUNTY MARYLAND buriot b. CITY OR TOWN (If outside corporate limits, write RURAL c. LENGTH OF STAY IN 16 c. CITY OR JOWN (If outside corporate limits, write RURAL and give negrest town) d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS 3. NAME OF _Middle First 4. DATE Last Month DECEASED (Type or print) DEATH 5. SEX 9. AGE |In years 6. COLOR OR RACE 7. MARRIED -NEVER MARRIED 1 8.1DATE OF BIRTH IF UNDER TYEAR and 3 to the retained t Months WIDOWED [DIVORCED | yrs. 10a. USUAL OCCUPATION (Give kind of work done 10b. KIND OF BUSINESS OR INDUSTRY 11 BIRTHPLACE (State or Agreign country) during most of working life, even if retired) 12. CITIZEN OF WHAT COUNTRY? pup 9 puo 13. FATHER'S NAME 14. MOTHER'S MAIDEN NAME 10 15/WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT Address PM3 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c),] -PART I. DEATH WAS CAUSED BY form IMMEDIATE CAUSE (a) DUE TO Canditions, if any, which pencil along buriolgove rise to immediate cause DUE TO (o), stoting the underlying cause lost pending in 0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0)[19. WAS AUTOPSY ö nseq at Examiner's 20g. EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING 20b. DESCRIBE NOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.) CAUSE OF DEATH. 20c. TIME OF INJURY Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE/OF INJURY (Home, form, 20f. (City or town) writing the willief Medical E 08: Page 3 sh factory, street, office bldg., etc.) Hour a. m. Not while at work of work p. m. 21. I certify that I took charge of the remains described above, held an Autopsy ... Inspection . Inquiry cute the celections, write forwarded to the Chief Private DIRECTOR: death resulted from: / Natural causes / Accident Suicide . Undetermined cause Hamicide . ACTUAL CHIEF MEDICAL EXAMINER SIGNATURE ASSISTANT MEDICAL EXAMINER removol **EXAMINER'S** NAME (Type) DEPUTY MEDICAL EXAMINER 229 BURIAL CREMATION, 226. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) REMOVAL (Specify) 0 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 240. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE Chillier S. Krous

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

e. IS RESIDENCE ON A FARM? YES NO

IF UNDER 24 HRS.

Min.

Hours

INTERVAL BETWEEN DNSET AND DEATH

PERFORMED?

NO I

(State)

and find that

DATE SIGNED

(Stote)

Doy

Days

(County)

essory, please exe-Page 4 should be

VS. A15ME(5) 5M 9/55

THU CAMPICAL EXAMINER'S DEI TRICHTE DE OLATR W. C.

13616

e. IS RESIDENCE

Hours

INTERVAL BETWEEN ONSET AND DEATH

PERFORMED?

NO 🗌

(State)

DATE SIGNED

(State)

un

YES [

(County)

DATE

Days

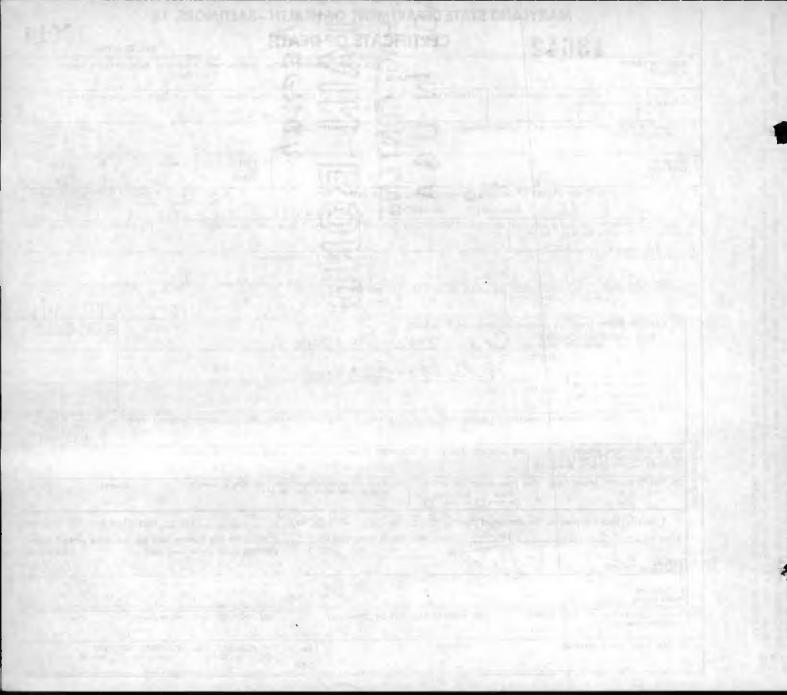
ON A FARM?

YES NO T

Year

19 60

VS A15 (4) 1SM 10/57



MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

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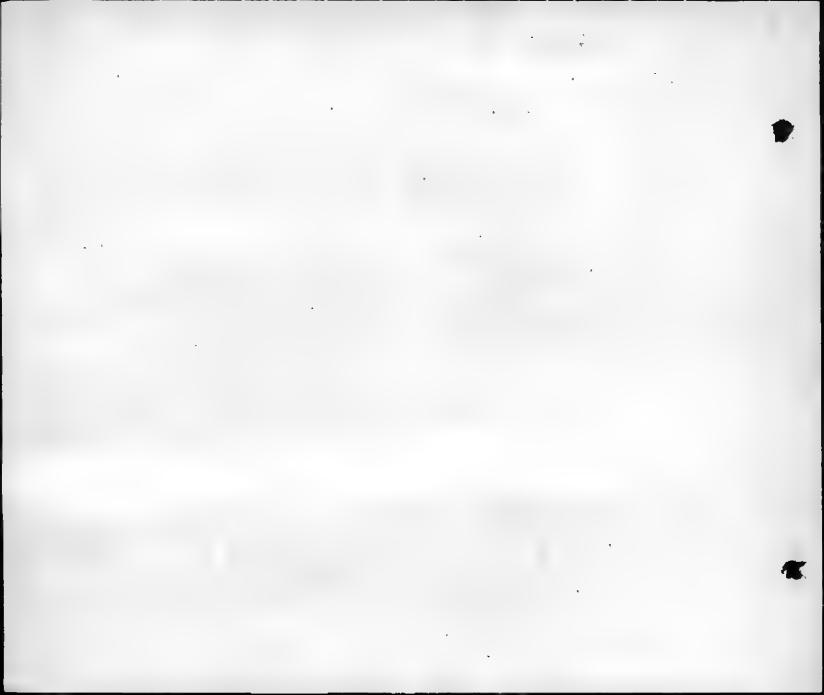
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	PLACE OF DEATH o COUNTY	Calvert		MARY			lary		d lived. If instituti b. COUNTY		ce befor		
1	CITY OR TOWN (If outside corporate immerest town) Frederick,	ts. write c.	LENGTH OF STAY 1 week	IN 16	CITY OR TO	•	utside corpo	rate limits, write R	URAL and g	give ned	arest town)	
	d. NAME OF HOSPI OR INSTITUTION Calvert	TAL (If not in hospitol, g	spital	(ress)		d. STREET ADD	ORFSS					e IS RESIDEN ON A FAI YES NO	RM?
3	NAME OF DECEASED	Fir	si	Middle		Losi		4. DATE OF	Mor		Do	•	
L	(Type or print)	Janie		s.		rover		UEATH	Decembe		14		60
5	female	6. COLOR OR RACE	7. MARRIED			anuary	31	1882	9 AGE (In years lost birthday) 78 yrs.	Months	Doys	Hours Hours	Min.
1	Oo USUAL OCCUPATI	ON (Give kind of work	rione 10h KIN							12, CITI	ZENOF	WHATCOU	NTRY
	Domesti	rking life, even if retired C	}	ome		Maryl			**		S.A		
ì	3. FATHER'S NAME	a a				14. MOTHER'S M							
	Stevens	G. Stalli	ngs			Prisci	llla	T. S	underlar	ıd			
1	S. WAS DECEASED EVE	ER IN U. S. ARMED FOR	CES? 16. 500	CIAL SECURITY NO	. 17 INFO	RMANT		,	Add	lress			
L	,		_		And	lrew W.	Grov	ver, (Owings,	Maryl	and	1	
	Conditions, if of gove rise to couse (o), stoting lying couse lost.	the under-	Keyps	eleun	iil	C.V./.	La	lise	2 and	WSALINI DAD	ONS	ERVAL BETWI	ATH
0.00	PARTIT OF	HER SIGNIFICANT CON	IUITIONS <u>CON</u>	AIK-BUIING 10 DE	BUI N	DI KEDATED TO S	HEIERMI	MAT DIZENZ	E COMPINON GI	A E) A I A . WK	1 1(0)	PERFORMI	ED?
	(IF EITHER, NOTIFY	'AS UNDERLYING DEATH CAUSE OF DEATH MEDICAL EXAMINER)	20b DESCRIE	BE HOW INJURY O	CCURRED.	Enter nature of i	njury in f	Port or Por	t il of item 18.)				
100	20c. TIME OF INJU	RY Manth, Doy, Ye	While _	IRY OCCURRED Not while of work	20s. PLAC focto	E OF INJURY (Hory, street, office b	me, farm oldg., etc.	, 20f. (City	y or town)	{c	County)		(Stote
21 1 certify that (I) (this haspital) aftended the deceased fram. 4 4 3 19, to 14 4, 1 saw the deceased alive an						nd an the	e date	at (1) (we stated at 22b Dz L4/60 ^{SI}	DOVE ATE				
	22c PHYSICIAN'S NAME (Type)	Dr. Georg	ge J.	Weems		22d ADDRESS	*	Hunti	ingtown,				
7	236 BLR AL, CREMATION. 23b DATE THEREOF 23c NAME OF CEMETERY OR CREMATORY 23d LOCATION (City, town, or county) Burial Dec. 17,1960 Mt. Harmony Cemetery Owings, Maryland												
1 2	HEUNERAL DIRECTOR		11	ADDRESS	(, 2	So. REC'I	D BY REGIS		ISTRAR'S SH	GNATU	RE	
	Stilchur	Funeral,	Home	- Mum	10 1	no -	DATE D	EC 2 0 '	60 (with a	. The	MA	

may be retained by the haspital or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and campletely filled in by the funeral director, page 3 shauld be detached far use as the burial-transit permit. Then please remaye carbon papers. Palles I and 2 should be filled with the State Board of Health prior to burial, cremation, or remayal, and in any event, within 72 hours after death death. Page 4 ATTEMDING INVSICIAN: The law requires that the death certificate be executed within 24 llaurs TO HOSPITAL

VR A15 (4) 15M 9/59



Reg. Dist. No. cremotion PLACE OF DEATH 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. COUNTY c. STATE b. COUNTY MARYLAND b. CITY OR TOWN III outside corporate limit, write RURAL c. LENGTH OF STAY IN 1b c./CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) tive recreat town? d. HAME OF HOSPITAL OR INSTITUTION (1) not in hospital, give street address) e. IS RESIDENCE d. STREET ADDRESS ON A FARM? dir. YES NO K 3. NAME OF 4. DATE Lost Month Day Year DECEASED OP DEATH 19 6 (Type or print) 9. AGE (In years 5. SEX 6. COLOR OR RACE 7. MARRIED THEYER MARRIED TO 8. DATE OF BIRTH IF UNDER TYPAR 1F LINDER 24 HRS. fost berthday) Months Days Hours Min. WIDOWED T DIVORGED [2 yrs. 10a, USUAL OCCUPATION (Give kind of work done 10b, KIND OF BUSINESS OR INDUSTRY during most of working life, even if retired) 11. BIRTHPLACE (S)ole or foreign country) 12. CITIZEN OF WHAT COUNTRY? puo U.S.A. Farmer Retired Md. 13. FATHER'S NAME 35 1 S 14. MOTHER'S MAIDEN NAME Charles E. Hannon Sarah (Unknown) 15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. MITGEMANT Calvert County Hospital No Unknown P.M.3. 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b); and (c).] INTERVAL BETWEEN ONSET AND DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) OT BUCK Conditions, if any, which long buriel gove rise to Immediate cause **DUE TO** (a), stoling the underlying couse lost. FART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19. WAS AUTOPS ő PERFORMED? YES [NO [20g. EXTERNAL CAUSE WAS PRIMARY DOOR CONTRIBUTING DEATH. OCCURRED. (Enter nature of injury in Port I or Port II of item 18.) CERT should Month, Day, Year 20d. INJURY OCCURRED 20e. PLACE OF INJURY (Home, form, 20r TIME OF INJURY (County) (State) factory, street, office bldg., etc.) While Not while at work 🔲 of work 21. I certify that I took charge of the remains described above, held an Autapsy []. Inspection . Inquiry and find that death resulted frams Natural causes . Accident / Svicide | Hamicide . Undetermined cause to the Chic DATE SIGNED ACTUAL CHIEF MEDICAL EXAMINER | forwarded to ASSISTANT MEDICAL EXAMINER **EXAMINER'S** DEPUTY MEDICAL EXAMINER NAME (Type) 220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d. LOCATION (City, town, or county) REMOVAL (Specify) 12/16/1960 Bumpy Oak Cemetery Pomonkey . Maryland 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 24b. REGISTRAR'S SIGNATURE 24o. REC'D BY REGISTRAR Archart Funeral Home . Inc. - La Plata Md. DATECO 2 0 160 5M 9/S5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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VS. A1SME(S)



VS A15 (4) 15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

	13645 CERTIFICA	TE OF DEATH	Reg. Dist. No. 13619
,	CALVERT MARYLAND	d. SIAIE Mp	d If institution Residence before admission) b COUNTY CALVERT
1	b. CITY OR TOWN (If outside corporate limits, write RURAL and give neagest-town) RURAL ond give neagest-town) RURAL ond Give neagest-town) A NAME OF HOSPITAL (If not in hospitof, give street address) OR INSTITUTION	C. CITY OR TOWN (If outside corporate PRINCE FREDE) d. STREET ADDRESS	e. IS RESIDENCE
10	3. NAME OF FIRST COUNTY HOSPITAL	Last 4. DATE	Month Day Year
	DECEASED (Type or print) A URICE & HUI 5. SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED B.	DATE OF BIRTH 19. A	DEC. 8 1960 GE (In years UF UNDER 1 YEAR) IF UNDER 24 HRS
į	W WIDOWED DIVORCED	Nov. 5, 1903	st birthday) Months Days Hours Min
	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARM OWNER FARMINE	0 0	12. CITIZEN OF WHAT COUNTRY
	HARRY HUTCHINS	VIRGINIA CA	RAWFORD
	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16 SOCIAL SECURITY NO. 17. INI [Yes, no, or unknown] [If yes, give wor or dates of services]	FORMANT SZEL HUTCHIA	Address 'S - PR. FREDERICK
	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o)	JASTRIC UL	INTERVAL BETWEEN ONSET AND DEATH
	Conditions, if any, which gove rise to immediate (b)	THERADY	1 year
	cause (a), stating the under- tying cause last. DUE TO (c) for A HE U.A.	ATLID ART	HAITIS 109 car
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT N		PERFORMED? YES NO
	OK CONTRIBUTING LI CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	(Enter noture of injury in Part I or Part II o	Filem 18.)
	20c. TIME OF INJURY Month, Day, Yeor 20d. INJURY OCCURRED While Not while of work of work	E OF INJURY (Home, form, 20f. (City or tory, street, office bldg., etc.)	own) (County) (State)
	21. I certify that I attended the deceased fram (M) 6 alive on The S , 1946, and that death of	occurred at 3 M, from th	, 19,00, that I last saw the deceased e causes and an the date stated above
	ACTUAL SIGNATURE SIGNATURE	D. ADDRESS (Street	city or town, state) DATE SIGNED DECEMBER 12 12 12 12 12 12 12 12 12 12 12 12 12
	PHYSICIANS PAGE OF JETT	PRINCE F	PEDERICK, 199
	220. BURIAL, CREMATION, 22b. DATE THEREOF 22c. NAME OF CEMETERY OR INCOMPRESSION DEC. 11, 1960 ASBURY CE	CREMATORY 22d. LOCATION	(City, town, or county) (Stote) W - CALVERT Co - MD
	23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Q. a. Harkings 420w - Muteral	240. REC'D BY REGISTRAR DEC 1 2 60	246 REGISTRAR'S SIGNATURE CITTUM S. Heard

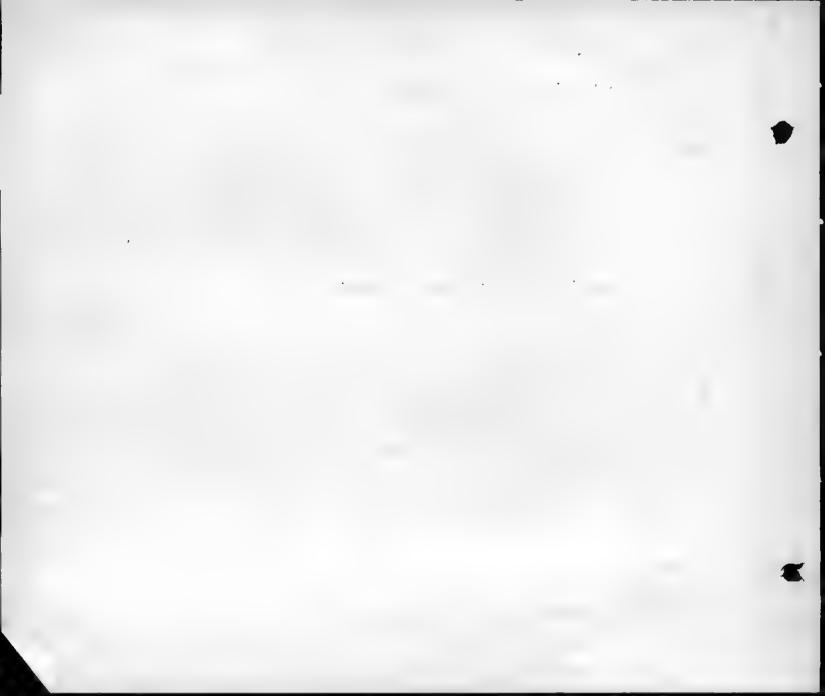
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MARYLAND	STATE D	DEPARTMENT	OF HEALTH-	BALTIMORE,	18
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13646	CERTIFICA	ATE OF DEATH		Reg. Dist. No. 1362
1. PLACE OF DEATH G COUNTY	MARYLAND	o. STATE Mary	Euch b. COUNTY	- Well
RURAL and give nearest rown)	c. LENGTH OF STAY IN 16	c. CITY OR TOWN IIF outs	ide corporate limits, write RU	JRAS and give nearest lawn)
d NAME OF HOSPITAL (If not in hospital, give street or OR INSTITUTION	ddress)	d STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES NO
3. NAME OF DECEASED (Type or print)	Middle	John Soy	OF DEATH	h Day Year - 2 4 19 6 6
5. SEX 6. COLOR OR RACE 7. MARRIE	DIVORCED	8. DATE OF BIRTH	9 AGE (In years last birthday)	IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work dane 10b K during most of working life, even if retired)	IND OF BUSINESS OR INDU	STRY 11. BIRTHPLACE (State or		12 CITIZEN OF WHAT COUNTRY
(Yes, no. or unknown) (If yes, give wor or dates of service)	OCIAL SECURITY NO. 17. 1	NFORMANT	AE Addr	E53
18. CAUSE OF DEATH (Enter only one cause per line PART I, DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)	INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), staling the underlying cause last. DUE TO DUE TO				
PART II. OTHER SIGNIFICANT CONDITIONS CO	ONTRIBUTING TO DEATH BUT	NOT RELATED TO THE TERMINA	L DISEASE CONDITION GIVE	N IN PART I(6) 19 WAS AUTOPSY PERFORMED? YES NO
(IF EITHER, NOTIFY MEDICAL EXAMINER)	RIBE HOW INJURY OCCURRE	D. (Enter nature of injury in Part	l or Part II of item 18.)	
20c. TIME OF INJURY Manth, Day, Year 20d. INJ Heur e. m. While of work	Not white ta	ACE OF INJURY (Home, form, clary, street, affice bldg., etc.)	20f. (City or town)	(County) (State)
21. I certify that I attended the deceased alive an 19 ACTUAL SIGNATURE NAME (Type)	7			,that I last saw the decease nd an the date stated abov late) DATE SIGNE
22a (BURIAL) CREMATION, 22b DATE THEREOF 12 - 1 8, 60	22c. NAME OF CEMETERY O	R CREMATORY 22	d. LOCATION (Gity, lawn, or	county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE P.E. 5 CLUEBL PLANS	40 Trede	240. REC'D B	2 701	TRAR'S SIGNATURE



	MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
ů,	13647 MEDICAL EXAMINER'S CERTIFICATE OF DEATH Reg, Dist. No. 13621
	1. PLACE OF DEATH a. COUNTY AMARYLAND 2. USUAL RESIDENCE (Where deceased lived. If Institution, Besidence before admission) b. COUNTY American
(IVI)	b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
X-	d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) d. STREET ADDRESS e. IS RESIDENCE ON A FARM?
5	3. NAME OF DECEASED Lost 4. DATE Month Doy Year
9 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(Type or print) (T C C 2 2 19 6 (Type or print) (T C C 2 2 19 6 (Type or print) (Type or print
	100. USUAL OCCUPATION (Give kind of work done) 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country)
	during most of working life, even if retired)
	13. FATHER'S NAME 14 MOTHER'S MAIDEN NAME 15 CC 15 C
E .	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. INFORMANT (You, no, or unknown)
	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED 8Y: CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).]
	H H DUE TO DUE TO
	Conditions, if eny, which gove rise to Immediate cause (o), stating the underlying couse last,
	PART II. OTHER SIGNIFICANT/CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(0) 19 WAS AUTOPSY PERFORMED? YES 1 190
	20d EXTERNAL CAUSE WAS PRIMARY OF CONTRIBUTING CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)
	20c. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e PLACE OF INJURY (Home, form, Public of work of wo
	21. I certify that I took charge of the remains described above, held on Autopsy [], Inspection [], Inquiry [], and find the
	death resulted from: Natural causes 4. Accident , Suicide , Homicide , Undetermined cause .
- / - 0	ACTUAL SIGNATURE DATE SIGNED ASSISTANT MEDICAL EXAMINER (1)
mava,	EXAMINER'S NAME (Type) DEPUTY MEDICAL EXAMINER (Type)
ar remaval.	220 BURIAL/CREMATION, 27b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY 22d LOCATION (City, town, or county) (Stote)
JE(5)	23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 4 246. REGISTRAR 246. REGISTRAR'S SIGNATURE
5	Y. J. Delett, Hrunce + the collect - DATE AN " O? Joillan S. thous



IO HOSPIT IN ATTENDING EHYSICIAN: The law requires that the death certificate be executed with 24 hours after a death. Page by be retained by the hospital or attending physician.

Yes TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral addition, page 3 should be detached for use as the burial-transfreethit. Then please remove carbon papers. Pages I and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

	,	MAKILAMU SIAIE DE!	AKIMENI O	HEALI	B	
DIVISION	OF STATISTICAL	RESEARCH AND RECORDS,	301 W. PRESTON	STREET,	BALTIMORE 1,	MARYLANDO O O
	13648	CERTIFICATE	OF DEATH			19047

	4	
Ė	1 PLACE OF DEATH	2. USUAL RESIDENCE (Where decessed lived, If institution, Residence before admission)
4	CALVERT MARYLAND	b. STATE MO. B. COUNTY CALVERT
	b. CITY OR TOWN (if outside corporete limits, c. LENGTH OF STAY IN 16 write RURAL and give nearest town)	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
	HUNTINGTOWN LIFE	I HUNTING TOWN
	d. NAME OF HOSPITAL OR INSTITUTION (if not in haspital, give street eddress)	d. STREET ADDRESS e. IS RESIDENCE
		ON A FARM? YES NO
	3. NAME OF First Middle	Last 4. DATE Month Day Year
	(Type or print) LILLIE GIBSON	LYONS DEATH DEC. 22, 1960
		DATE OF BIRTH 19. AGE (In yeers IF UNDER 1 Y AK IF UNDER 24 HRS.
		last birthdey) Months Days Hours Min.
	W WIDOWED DIVORCED	OET. 24, 1871 89 yrs.
	10s. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
	HOUSE WIFE HOME	MARYLAND U.S.A.
	0	
	15. WAS DECEASED EVER IN U.S. ARMED FORCES? 16. SOCIAL SECURTY NO. 17. EL	SARAH JANE LYON3 Address
	(Yes, no, or unkown) (Hyesgive war or detes of service)	MUEL LYONS - PA. FREDERICK, MO.
	18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).)	I INTERVAL BETWEEN
	0.	ONSET AND DEATH
	PART I. DEATH WAS CALSED BY. IMMEDIATE CAUSE (B) (FREBRAL AND	Z MORRES
	OT BUG	T
	Conditions, if any, which (b) AURICULAR /	FIBRILLATION 1935
	gave rise to immediate cause	
	(a), stating the underlying Cause lest.	
		T RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a), 19. WAS AUTOPSY
	Carcaconia (Enclicion	PERFORMED?
		MICH TES NOW
	20b. ACCIDENT WAS UNDERLYING TO 20b. DESCRIFE HOW INJURY OCCURED. OR CONTRIBUTING TO CAUSE OF DEATH OF EITHER, NOTIFY MEDICAL EXAMINER)	(Enter neture of injury in Part I or Pert II of Item 18.)
	3 20c. TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED 20c. PLA	CE OF INJURY (Home, farm, 20f. (City or town) (County) (State) ory, street, office bldg., etc.)
	20c. TIME OF INJURY Month, Day, Yeer 20d. INJURY OCCURRED 20e. PLA Hour a.m. p.m. 19 at work at work	ory, street, office blogs, etc./
	21. I certify that (I) (this hospital) attended the deceased from	De C 2 1960 to QCC 22 1960 that (1) (we) last
	21. I certify that (i) (this hospital and the deceased home	death occured at 9.4.M, from the causes and on the date stated above.
		22b. DATE
	22a, AfgNASURE	ATTENDING MED. STAFF
		D. PHYS. DIRECTOR PHYS. 7
	NAME (Type) PAGE 10 157 - 177	
	THUE COLD TOLL	2 TRINCE TREDERIOR Ma
	23a. BURIAL, CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY (REMOVAL (Specify)	
	BURIAL DEC, 26, 1960 MIRANDA CE	EMETERY HUNTINGTOWN. MD.
	24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25e. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE
4	AIA. HARKNESS & SON - MOTUAL	MD DATE DEC 2 8 '60 anthon & thous
		1 A MANA



	13649	()
R.	a. COUNTY Calvo	1
3	b. CITY OR TOWN (If autside carporate RURAL and give nearest town)	r lic Z

may be revained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the fune director, page 3 should be detached far use as the burial-transit permit. Then please randove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, ar removal, and in any efect, within 72 hours after death. rent within 72 hours after death.

death. Page 4

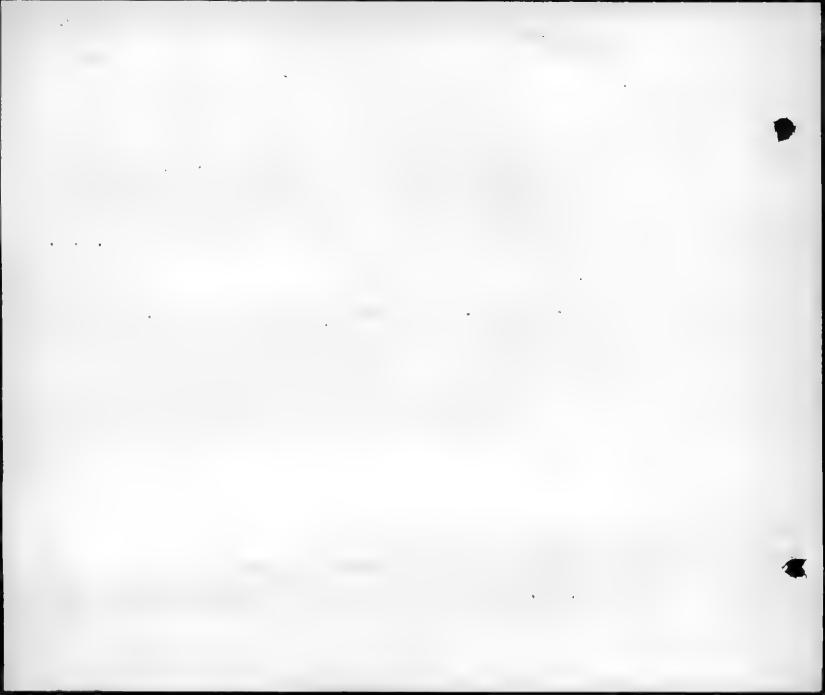
ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours

TO HOSPITAL VR A15 (4) 15M 9/59

1. PLACE OF DEATH a. COUNTY A. A	2. USUAL RESIDENCE (Where deceased tived. If institut on Residence before admission) a. STATE b. COUNTY
b. CITY OR TOWN (If autside corporate limits, write RURAL and give nearest town) The state of t	c. CITY OR TOWN (If autside carporate limits, write RURAL and give nearest lawn)
d. NAME OF HOSPITAL (If not in haspital, give street address) OR INSTITUTION 2/Vert County Hospital	de Street address e. IS residence on a farm? YES NO
3. NAME OF DECEASED (Type or print) Mary Mabel	Pardice 4. DATE Manth Day Year OF DEATH D. Mt 1 14 1966
5 SEX 6. COLOR OR RACE 7. MARRIED NEVER MARRIED DIVORCED DIVORCED	B. DATE OF BIRTH 9. AGE (In years IF UNDER 1 YEAR IF UNDER 24 HR lost birthday) Manths Days Haurs Min.
100 USJAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK HOME	Md 21.5.H
Reverdy Jenes	Mary Monnett
15. WAS DECEASED EVER IN U S. ARMED FORCES? 16. SOCIAL SECURITY NO. (If yes, give wor or dates of service)	Tumes W. Pardo: Lushy, n.d
1B. CAUSE OF DEATH [Enter only one couse per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise Ia immediate cause (a), stoting the under-lying cause last. (c)	enlargement 7 heart
	UT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) 19. WAS AUTOPS PERFORMED? YES NO
20b. DESCRIBE HOW INJURY OCCUR OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	RED. (Enter nature of injury in Part I ar Part II of item 18.)
ZOc. TIME OF INJURY Month, Day, Year 20d INJURY OCCURRED 20e. Hour a. m. p m 19 While at wark of work	PLACE OF INJURY (Hame, farm, factory, street, affice bldg., elc.) (City ar tawn) (Caunty) (Statement, affice bldg., elc.)
	death accurred at 1/2 M, from the causes and an the date stated above
22a SIGNATURE I Glevillanes	MD PHYS DIRECTOR PHYS DIRECTOR
120c PHYSICIAN'S NAME (Type) D. VITTING 1 1 MO	St Leinith Md.
230 BURIAL CREMATION, 236, DATE THEREOF 230 NAME OF CEMETERY SUrval Dec. 17,1960 Middleham	Chapel Cemetors Lusby Calvert Co. Md.
24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS ADDRESS ADDRESS ADDRESS	250. REC'D BY REGISTRAR / 256 REGISTRAR'S S GNATURE

VR A15 (4) 15M II/59

		TOBBO		CEKI	IFICAT	E OF DE	АІП						
1. PL a.	ACE OF DEATH COUNTY Calvert			MA	RYLAND	a STATE	land	ere deceased	lived. If institute b. COUNTY	on: Resider	nce befo	re odmissi	ion)
Ь			ts, write	c LENGTH OF STA	AY IN 15		OWN (If ou	itside carpo	rate limits, write R		give nec	irest town)
d.	OR INSTITUTION	ounty Hosy		address)	•	d. STREET AC							DENCE FARM?
DI	AME OF ECEASED ype or print)	John		Midd Wes]		Lost R	lig 's	4. DATE OF DEATH	Decem		22 22	3	19 60
5 SE	x Jalo	6 color or race Negro	7. MARI	RIED NEVER MAR		date of Birth June 27			9. AGE (In years last birthday) 51 yrs	Months Months	Days	Hours	R 24 HRS Min
-ye	USUAL OCCUPATIO during/most of worki	N (Give kind of working life, even if retired	done 10b.	KIND OF BUSINESS	OR INDUSTR		CE (Stote of	r foreign o	ountry)	12 CIT		S. A	
13. F/	ATHER'S NAME					14. MOTHER'S	MAIDEN N	AME					
	Columbus						tie H	all					
		IN U. S. ARMED FOR f yes, give wor or dates of t		79220	1000	darrie E	liggs	В	ristol.		and		
	Canditions, if an gave rise to in cause (a), stoting t lying cause lost.	mediate (Duc To)	CONTRIBUTING TO E	DEATH BUT N	OT RELATED TO	THETERMIN	VAI DISEAS	E CONDITION GIV	VEN IN PAR	RI](a)]]	9 WAS A	AUTOPSY
IFICATION	100 ACCIDENT WAS			CRIBE HOW INJURY								PERFO	RMED?
IL CERT	OR CONTRIBUTING IF EITHER, NOTIFY I Oc. TIME OF INJURY	CAUSE OF DEATH MEDICAL EXAMINER) Month, Day, Ye	a∈ 20d II	NJURY OCCURRED	20e. PLAC	F OF INJURY (H	lome, form,	20f (City		(County)		(State)
2	Hour a.m. p. m. 21. I certify that saw the decease 22a. SIGNATURE 22c. PHYSICIAN'S NAME (Type)	Dee	1/32	led the decease	d fram	ath accurred	ats S	60 , ta_	13/2 d the couses ar	, 19_1 and an th			
	BURIAL, CREMATION REMOVAL (Specify)	Dr. Geo.		23¢ NAME OF CE	METERY OR			town,	Marylan			(State	0)
24 Ft	JNERAL DIRECTOR'S	SIGNATURE DE LUCL	Pro	ADDRESS.	uch			BY REGIST 2 9 '6		STRAR'S SI			



1	o. COUNTY MARYLAND	o. STATE b. COUNT	before admission)
	b. CITY OR TOWN (If outside corporate limits, write c. LENGTH OF STAY IN 1b RURAL) and give nearest town)	e-CITY OR TOWN (If outside corporate limits, write RURAL and g	ive nearest town)
	d. NAME OF HOSPITAL (If not in hospital, give street oddress) OR INSTITUTION	d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES NO
	3. NAME OF DECEASED (Type or print) On all the Middle	4. DATE Month OF DEATH	Doy Yeor / 22 1950
	WIDOWED DIVORCED	Hel 1961 lost birthdoy) Months	1 YEAR IF UNDER 24 HRS Days Hours Min.
	10o. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Med 1	ZEN OF WHAT COUNTRY?
1	S. FATHER'S NAME	14. MOTHER'S MAIDEN NAME Hassis	
1	15. WAS DECEASED EVER IN U. S. ARMED FORCES? 16. SOCIAL SECURITY NO. 17. IN	Address Address	
	18. CAUSE OF DEATH [Enter only one couse per line for (o), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (c) DUE TO Conditions, if any, which gove rise to immediate couse (o), storing the under-lying couse lost. (c)	Junia	INTERVAL BETWEEN ONSET AND DEATH
	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT I	NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PAR	19. WAS AUTOPSY PERFORMED? YES NO
	OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)). (Enter noture of injury in Port I or Port II of item 18.)	
		CE OF INJURY (Home, form, 20f. (City or town) (Coty, street, office bidg., etc.)	County) (State
		eath accurred at 45 M from the causes and an the	
	22clPHYSICIAN'S	M.D. ATTENDING MED. MED. STAFF PHYS. 22d. ADDRESS	22b. DATE SIGNED
	NAME (Type)	Juny Med	At the Co
	230 BURIAL CREMATION, 23b. DATE THEREOF 23c. NAME OF CEMETERY OF ST. ECIM	made Sunderlas, Cal	(Store)
	24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS P. TEUVELL: Grunge Freedom	250. REC'D BY REGISTRAR 25b. REGISTRAR'S SIG	1.0

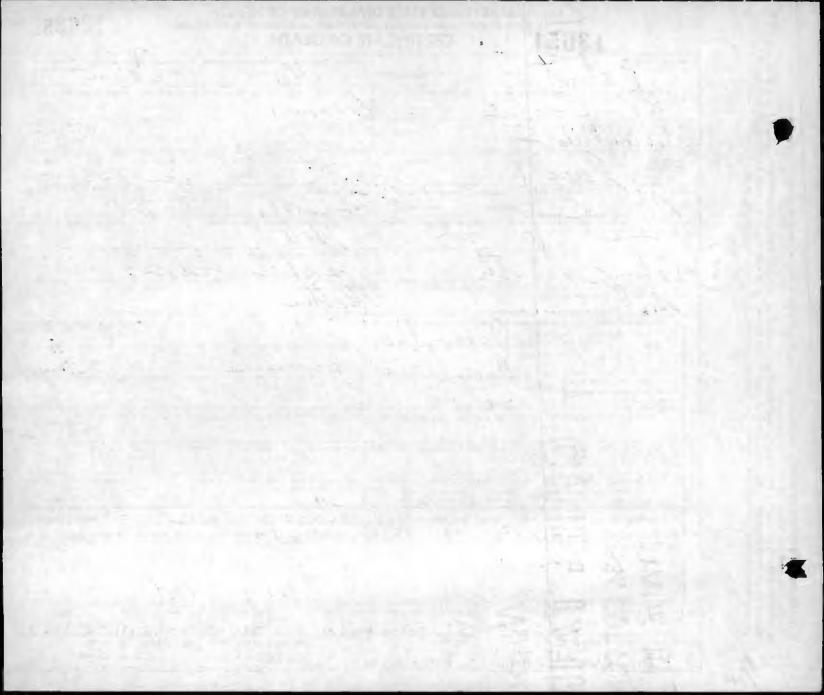
may be retained by the hospital or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the page 3 should be detached for use as the burial-transit permit. Then please remave corbon papers. Pages 1 and 2 shouthe State Board of Health prior to burial, cremation, ar remaval, and in any event, within 72 haurs after death. ITENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours TO HOSPITAL

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r death. Page 4

VR ATS (4) 15M 9/59



TO HOSPITA

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MAR

CERTIFICA 13659

AND	KECOKD2 - RAI	LIIMORE I, MAKTLAND	110000
ATE	OF DEAT	H	13626

1. PLACE OF DEATH o. COUNTY CALVERT MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY calvert							
b. CITY OR TOWN (If RURAL ond give nee Prince Fred	arest town)	its, write	c. LENGTH OF STAY IN 16		Prince		ote limits, write R	URAL ond g	ive neare:	st town)		
d. NAME OF HOSPITA OR INSTITUTION Calvert Co		d. STREET	d. STREET ADDRESS									
3. NAME OF DECEASED (Type or print)	Fin Hen		Middle	Wood	osi	4. DATE OF DEATH	Decei		Day 13	Year 1960		
5. SEX	6. COLOR OR RACE	T 8/	RIED NEVER MARRIED	B. DATE OF BIR	189	79	O. AGE (In years lost birthday) yrs.			Hours Min.		
10a. USUAL OCCUPATIO	N (Give kind of work ing life, even if retired	done 10b.	KIND OF BUSINESS OR IND		Marylan	nd	untry)	12. CITIZ	U.S.	/HAT COUNTRY?		
Willia					inia De	ent e n						
15. WAS DECEASED EVER (Yes, no, or unknown)	R IN U. S. ARMED FOR	RCE57 16.	• ?	informant rs. Harr	v Conn	er. Pr	ince Fr		k. M	d.		
Conditions, if on gove rise to in couse (o), stoling t lying couse lost.	the under-)) :)	Least Ja Cronary e CONTRIBUTING TO DEATH BE	achere unffer IT NOT RELATED T		NAL DISEASE	CONDITION GI	VEN IN PART		WAS AUTOPSY PERFORMED?		
THE EITHER, NOTIFY	CAUSE OF DEATH	20b. DES	CRIBE HOW INJURY OCCURP	ED. (Enter noture	of injury in Po	ori I or Port	II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year 20d. INJURY OCCURRED While Not while of work of w												
21. I certify that saw the decease 220. SIGNATURE	1	attend 2 -/-	ded the deceased from	death accurre	. /		the causes or			(1) (we) last tated above 22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type)	RLEVI	264	RREDL M	22d. ADD	- Indian	6/	eo NA	nnd	, fl	15/15		
23g. BURIAL, CREMATION ROMOVAL (Specify)	Dec, 16, 19	60		or crematory		Bars7	ON (City, lown,	ert (301	Md,		
124 FUNERAL DIRECTOR'S	SIGNATURE SECOND	w 7	rutual, mo	1.	250. REC'D	BY REGISTR		STRAR'S SIG				

